



GROUP ENROLLMENT/CHANGE FORM
 P.O. BOX 45018 FRESNO CA 93718-5018
 (800) 442-7247 FAX (559) 499-2464

- New Enrollment
- Name/Address Change
- Reinstatement
- Rehire

- Annual Enrollment
- Change Enrollment
- Decline Coverage
- Termination

(Shaded area for office use only)

PART 1 EMPLOYEE INFORMATION													
EMPLOYER				PLAN CHOICE <input type="checkbox"/> EPO <input type="checkbox"/> PPO <input type="checkbox"/> STANDARD <input type="checkbox"/> OTHER				GROUP NUMBER		Benefit Type(s): <input type="checkbox"/> Medical <input type="checkbox"/> Dental <input type="checkbox"/> Vision <input type="checkbox"/> Rx <input type="checkbox"/> Life			
EMPLOYEE LAST		FIRST		MI	SS #					EFFECTIVE DATE			
										MED	DEN	VIS	
ADDRESS STREET		CITY		STATE	ZIP CODE			HOME PHONE ()		BIRTHDATE	MO	DAY	YEAR
HIRE DATE		JOB TITLE OR RETIRED		SALARY		<input type="checkbox"/> HRLY <input type="checkbox"/> MNLY <input type="checkbox"/> YRLY		LIFE AMT. \$		<input type="checkbox"/> MALE <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED		DEPARTMENT	
										<input type="checkbox"/> FEMALE <input type="checkbox"/> MARRIED <input type="checkbox"/> DIVORCED			
BENEFICIARY			RELATIONSHIP			SS #		Primary Care Physician (EPO Plan only)			Physician Phone Number and Address		
EMPLOYEE TERMINATION DATE		REASON								ID CARD FORMAT		MASK	

PART 2 DEPENDENT INFORMATION												
DEPENDENT INFORMATION (List persons to be covered/terminated.): ¹ Relationship Code (relationship to participant) SPO=Spouse SON=Son DAU=Daughter DEP=Other Dependent										² Benefit Type(s): M=Medical D=Dental V=Vision Rx=Prescription		
Add/Drop	Last Name	First Name	MI	Social Security Number	Birth Date	Gender (Circle)	1 Rel. Code	2 Benefits (Circle)	Full Time Student	Disabled	Primary Care Physician (EPO Plan Only) Name Address & Phone #	
A D						M F		M D V Rx	Y N	Y N		
A D						M F		M D V Rx	Y N	Y N		
A D						M F		M D V Rx	Y N	Y N		
A D						M F		M D V Rx	Y N	Y N		
A D						M F		M D V Rx	Y N	Y N		

IF ADDING OR DROPPING DEPENDANT STATE REASON:

PART 3 OTHER INSURANCE INFORMATION									
ARE YOU OR ANY OF YOUR DEPENDENTS (INCLUDING SPOUSE) COVERED UNDER ANOTHER HEALTH PLAN OR MEDICARE? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, PLEASE COMPLETE THIS SECTION. Check if additional form attached. <input type="checkbox"/>									
Name of other policy holder	Birth Date	Social Security Number	³ Rel. Code	Sponsoring Employer	Insurance Carrier or Medicare	Group Number	⁴ Benefit Types	⁵ Policy Types	Coverage Date(s) Begin / / End / /

PERSONS COVERED UNDER ABOVE POLICY:

³ Relationship Code (specify relation to participant): SPO=Spouse OTH=Other ⁴ Benefit Type(s): M=Medical D=Dental V=Vision Rx=Prescription ⁵ Policy Type(s): IND=Individual Policy GRP=Group Plan HMO=Health Maintenance Organization MED=Medicare

PART 4 COVERAGE DECLINATION	
To be completed if any coverage is declined or refused by an eligible employee and / or their eligible family members;	
HEALTH PLAN COVERAGE (CHECK IF DECLINED) I decline coverage for: <input type="checkbox"/> Myself <input type="checkbox"/> Children <input type="checkbox"/> Spouse <input type="checkbox"/> Spouse and Children	REASON FOR DECLINING HEALTH COVERAGE (CHECK IF DECLINED) <input type="checkbox"/> Covered by spouse's group coverage <input type="checkbox"/> Medicare <input type="checkbox"/> Spouse covered by employer's group medical coverage <input type="checkbox"/> Other (explain) _____
I acknowledge that the available coverages have been explained to me by my employer, and I know that I have every right to apply for coverage. I have been given the chance to apply for this coverage and I have decided not to enroll myself and/or my dependent(s), if any, and understand that evidence of insurability may be required should I choose to apply for coverage at a later date. I have made this decision voluntarily, and no one has tried to influence me or put any pressure on me to decline coverage.	
If declining coverage for employee/dependent(s) please sign here. _____ Date _____	

PART 5 DECLARATION	
<input type="checkbox"/> I hereby request the amount of coverage for which I may become eligible under the group employee benefits plan of my employer and authorized payroll deductions from my earnings (if any) required to cover my share of the premium. I confirm the above beneficiary information.	
Employee's Signature _____	Date _____